Hawaii's Public Mental Health System

Debra J. VanderVoort PhD

Debra J. VanderVoort PhD

Abstract

The following article addresses the nature of and problems with the public mental health system in Hawaii. It includes a brief history of Hawaii's public mental health system, a description and analysis of this system, economic factors affecting mental health, as well as a needs assessment of the elderly, individuals with severe mental illness, children and adolescents, and ethnically diverse individuals. In addition to having the potential to increase suicide rates and unnecessarily prolong personal suffering, problems in the public mental health system such as inadequate services contribute to an increase in social problems including, but not limited to, an increase in crime rates (e.g., domestic violence, child abuse), divorce rates, school failure, and behavioral problems in children. The population in need of mental health services in Hawaii is under served, with this inadequacy of services due to economic limitations and a variety of other factors.

History of Hawaii's Mental Health Delivery System

The public mental health system in Hawaii has had many problems in its history. In 1974, the Hawaii State Hospital (which provided the only state funded long-term inpatient mental health services) lost accreditation by the Joint Accrediting Association of Hospitals due to deficiencies in staffing and record keeping[1]. In 1986, Hawaii was rated fifty-first in the country for the care of individuals with severe mental illness (SMI) by the Public Citizens Health Research Group[2]. In this same year, the Hawaii State Hospital lost federal certification for Medicare and Medicaid reimbursements as the federal inspection team found a variety of problems such as civil rights violations, lack of active treatment programs, and leaky roofs. Given the low priority of mental health services (only one percent of the total government budget was spent on mental health in 1986, which ranked it fourty-sixth in the nation), lack of funding was one of the major reasons for the poor condition of the state hospital.

Services for children were particularly inadequate in the 1980s, with Department of Health (DOH) data revealing that state mental health facilities provided services to only 2,193 of the estimated 17,000 children and adolescents with severe and potentially chronic mental health problems in 1986[1]. However, adult individuals with SMI did not fare much better as only 900 of the more than 10,500 such individuals were receiving services from the State's mental health system in 1988[1]. In this same year, Hawaii was again ranked fifty-first in the country by the Public Citizens Health Research Group and the National Alliance for the Mentally Ill in providing care to individuals with SMI in terms of: (1) dollars expended per individual; (2) number of staff and services available at the community level; and (3) quality of hospital and other institutional care[1]. One reason for the lack of staff (and quality of staff) was that compensation for mental health professionals in Hawaii was among the lowest in the country.

The 1990s also saw many problems. In 1990, for the third consecutive time, the Public Citizens Health Research Group rated Hawaii's mental health program as fifty-first in the nation and Hawaii ranked fourty-third in per capita spending on mental health services[3]. They also claimed that the DOH virtually squandered a $2.5 million Robert Wood Johnson Foundation grant intended for reform of the system but instead was used primarily to hire expensive consultants and create more complex levels of bureaucracy and administration[3]. In 1991, the United States Justice Department filed suit against the State of Hawaii on the grounds of violating the civil rights of hospital patients at the Hawaii State Hospital due to inadequate care and unsafe living conditions. Another lawsuit against the State of Hawaii was filed in 1991 by the Protection and Advocacy Agency of Hawaii, Inc. for closing the adolescent unit at the Hawaii State Hospital and subcontracting these services to facilities in the private sector. In the 1990s, state mental health services provided for children and adolescents were still seriously deficient with only about 10% of the estimated needs for outpatient care being met by children's teams at the community mental health center. Indeed, DOH Director Lewin viewed this problem as the State's greatest public health emergency[4]. In 1993, six community agencies filed a class-action suit against the State in federal court for failing to provide appropriate children's mental health services, education, and treatment[5]. However, plans were underway for improvement of the Child and Adolescent Mental Health Division as well as the Adult Mental Health Division of the Behavioral Health Administration (BHA), and in 1993, the Clinton administration approved Hawaii's proposed QUEST health program for lower-income residents. The targeted programs included Medicaid's Aid to Families with Dependent Children, General Assistance, and the State Health Insurance program. The QUEST program

Debra VanderVoort PhD
University of Hawaii at Hilo
Social Sciences Division
Department of Psychology
200 W. Kawili
Hilo, HI 96720
(808) 974-7402
dvanderv@hawaii.edu

would increase Medicaid reimbursements for desperately needed mental health services and thus increase availability of services, given that financial difficulties were one of the primary reasons for the inadequacy of services coupled with the fact that Hawaii had the lowest percentage of federal reimbursements for state monies spent on mental health services of any state in the nation[1].

Hawaii's Current Public Mental Health System

Hawaii's current public mental health system is governed by the BHA which is comprised of three divisions: (1) Alcohol and Drug Abuse Division (ADAD); (2) Adult Mental Health Division (AMHD); and (3) Child and Adolescent Mental Health Division (CAMHD). Subsequent to the 1989 reorganization, these three divisions attained fiscal independence, which they did not experience previously. This allows for a more sound appropriation of funding given that the financial decision making is done by individuals more closely associated with client needs.

Problems with the Current Public Mental Health System in Hawaii

Based on interviews with stakeholders in the public mental health system, including BHA deputy directors, AMHD, ADAD, and CAMHD division chiefs, CMHC chiefs, local mental health advocates (including university and state mental health advisory council members), AMHD staff, private providers, and national experts and consultants (including a number of individuals who have been hired by the DOH in the past[1, 7]), as well as a review of other pertinent literature[6, 8, 9, 10], a number of problems with the system have been identified. Table 1 summarizes these problems.

The first problem is that policy decision functions are not separate from service delivery functions within AMHD and CAMHD. When policy and service functions all fall under the same administration, policy decisions about the provision of services are often determined by the interest of service providers rather than service consumers.

Another problem is that monitoring of the CMHCs by AMHD is not occurring on a regular basis as it should, in part due to the fact that the AMHD central office staff are too busy responding to daily crises which does not allow adequate time for effective planning and monitoring of services. Hence, detection of problems and plans for improvement do not happen on a timely basis.

Ineffectual accountability is another problem. Authority is placed with so many individuals within the BHA that no one appears to be accountable. Further, many CMHC professionals feel they are held accountable but lack adequate decision-making and budgetary authority. Although the treatment providers are the only ones close enough to client problems to be able to respond in a timely and effective manner to them, they often lack the control and authority to do so.

Table 1.— Problems with the Public Mental Health System in Hawaii
(1) Policy decision functions are not separate from the service delivery functions.
(2) Insufficient program monitoring.
(3) Ineffectual accountability.
(4) Insufficient supervision of clinicians.
(5) Budget problems and fiscal policies.
(6) Lack of timely recruitment and retention of needed and qualified staff.
(7) Planning deficiencies at the BHA.
(8) Lack of coordination between various types of service providers.
(9) Managerial problems within the BHA.
(10) Poor data management.
(11) Inefficient organizational infrastructure.
(12) Fiscal problems with service providers.
(13) Cost-inefficiency within the BHA.

A fourth problem is inadequate supervision of clinicians, particularly within the AMHD. In addition to lack of needed supervisory staff, the inordinate number of crises CMHC and other AMHD staff have to respond to make regularly scheduled supervisory meetings difficult to maintain.

Another problematic area involves budget problems and fiscal policies. Insufficient funds and resources is the foremost concern. Further, the budget of the CMHCs is unpredictable, insufficient to serve the number of clients in need, and out of the control of the CMHCs. One budget problem for the CMHCs is that funds allocated for them have often gone to the Hawaii State Hospital[7], resulting in an inadequate emphasis on outpatients services (which was one of the major reasons that the Robert Wood Johnson Foundation cut off almost $1,000,000 in grant money promised to Hawaii). Although there has been an increase in funding allocated to outpatient treatment for adults since 2000, a large proportion of the AMAD budget still goes to the state hospital[10]. These budget problems (particularly its unpredictability) make realistic planning very difficult, if not impossible, and prohibits the provision of adequate adult outpatient services[7].

The budgetary and bureaucratic problems previously described impede timely recruitment as well as retention of needed and qualified staff. Commonly, 30 percent of the CMHC positions are vacant. Part of the reason for this is that it can take up to five months for the Department of Personnel Services to approve filling a position and an additional four months to receive an approved internal list of applicants. If that list is inadequate, an external list must then be reviewed which results in further delays. It can actually take as long as two years to fill a given position, by which

time many, if not most of the applicants (particularly the most qualified) have found positions elsewhere. Another problem is the hiring of staff who lack the minimum qualifications for their position (e.g., lack of mental health work experience[10], failure to complete mandated training has been a problem with direct care staff at the Hawaii State Hospital[9]). In addition, many needed positions are lost because budget freezes do not allow them to be filled and when they remain unfilled for an extended period of time, the DOH Administrative Service Office retracts the position under the assumption that it is unnecessary. Reasons for these budget freezes include bureaucratic inefficiency and a desire to reduce or streamline mental health services. Lack of promotions (and hence retention) of superb staff is another problem as well as delays in promotion due to the fact that promotions are controlled by the personnel departments and not the CMHC managers.

Planning deficiencies at the BHA, resulting in avoidable crises[11], and lack of coordination amongst the various types of state service providers as well as between state agencies and private service providers are additional problems. The latter results in clients not knowing where to go for help as well as getting shuffled from agency to agency, with no one taking responsibility for their care. Further, this lack of coordination leads to failure to inform CMHC and other outpatient service staff of what services have been contracted for by the BHA and how to access them, which again leads to poor service delivery. This is particularly problematic for dual-diagnosed clients who are receiving services from two divisions within the BHA (e.g., ADAD and AMHD).

Managerial problems within the BHA constitute another problem. This contributes to poor communication within the central office and between the central office and the CMHCs as well as private service providers, which tends to be a chronic problem. Improvements are needed in management organization as well as in staffing for executive management functioning (e.g., data management system development, budget).

Poor data management is another major problem. Without adequate data management, cost-efficient services cannot be determined nor can changes be implemented where needed. For example, in studies (requested by the legislature) designed to assess whether privatization of the adult[6] and youth[8] mental health services has been clinically successful and cost-effective, definitive conclusions could not be drawn because the information and data needed to perform the proper analyses were lacking. Limited funding is a major etiological factor for this poor data management (e.g., inadequate computer resources). This leads to an inordinate amount of data handling time by AMHD and CAMHD staff which in turn results in a waste of limited funds. Further, information flow is hampered by having three segregated divisions within the BHA, each with their own offices, providing services that are not, but should be, well coordinated.

An additional problem is an inefficient organizational infrastructure, especially within the AMHD. The CMHC and other outpatient service staff often do not know what support is available or how to access it which is a function of both managerial and organizational confusion. The staff of the AMHD lack clearly defined roles and hence the CMHC and other outpatient service personnel do not know who to go to for various types of problems or needed services.

Fiscal problems with private service providers is another area of concern. Chronic delays in vendor payments to these providers has been so problematic that many private providers will not contract with the state, leading to a loss of access to some of the high quality mental health agencies. Fortunately, improvement in timely reimbursements to providers is being made[12]. However, other research on contracted community services for both youth and adults indicates that providers are sometimes paid without validation of invoices, without verification that the services were in fact rendered, and without evidence that the expenses were reasonable[8,10]. Improved data management is needed to help resolve these problems.

A final problem is cost-inefficiency within the BHA. There are five primary reasons for this: (1) present budgetary policies often encourage wasteful spending (e.g., funds that are not utilized by the end of the fiscal year revert to the state general fund which encourages agencies to utilize any leftover funds on unnecessary activities for fear of future budget cuts); (2) the system provides few incentives to deliver services in a cost-efficient manner (e.g., incentives to reduce the need for hospitalization, the most costly service); (3) a lack of continuity in the BHA's planning and policies which results in a lot of money being expended on the development and implementation of programs that are later altered significantly or abandoned (e.g., the six years spent on the development of a series of case management positions at the CMHCs which was never implemented, at a cost to the state of approximately $500,000); (4) complicated requirements of the present system result in institutional gridlock; and (5) the BHA lacks sufficient infrastructure and resources to be maximally cost-effective (e.g., insufficient equipment, staff positions, support services, and training, as well as an exceedingly poor record for securement of federal reimbursements and other sources of revenue).

Needs Assessment

To begin addressing some of the problems with the public mental health system in Hawaii, a variety of needs assessments have been conducted. The following groups are the most under served or unserved in the

State of Hawaii: individuals living in rural areas; those who are uninsured as well as low income populations; those on Medicaid; individuals in nursing homes; those in prisons; groups that do not have ready access to services; and native Hawaiians[10,13,14].

In addition, there are only 168 inpatient beds at the Hawaii State Hospital located in Honolulu and there are no long-term inpatient state psychiatric facilities on the outer islands. The latter is problematic for a number of reasons, perhaps the most salient being the isolation from the support of family and friends which can exacerbate their symptoms, given the well-known profound effect of social support on both mental and physical health.[15-19]

The Needs of the Elderly

As the population of elderly individuals is steadily increasinng[20] (and is expected to grow at four times the rate of the population as a whole[21]), the need for services for this population likewise increases. Over 20% of the elderly in long-term care receive services for mental health problems. Unfortunately, rural long-term care facilities for the elderly are virtually nonexistent. Over-medication and lack of adequate monitoring of medication (due to insufficient Medicaid/Medicare reimbursement for more frequent physician visits) is a problem with this population[13,21]. The elderly are also in dire need of a multidisciplinary team treatment approach (due to the bidirectional relationship between physical and mental health problems) but this rarely occurs. Obstacles to collaboration include competition for financial reimbursement in a system that impedes such collaboration, divergent theoretical orientations and insufficient knowledge about the treatment approaches of other healthcare professionals, and mental health facilities that lack the space or mechanisms to facilitate collaborative treatment of patients[13,21].

The Needs of the Severely Mentally Ill

The most important needs identified by the AMHD and other experts working with this population[7,22] include: (1) improved monitoring of medication, which is very important as appropriate medication allows many individuals with SMI to live in the community who would not otherwise be able to do so and can help reduce the high incidence of self-medication with illicit drugs[23]; (2) better crisis services (e.g., available services when the community mental health centers are closed); and (3) the need to identify the noninstitutionalized in need of services as this population is frequently unserved. Given the high rates of physical illness among individuals with SMI[24,25], the noninstitutionalized are often in need of medical as well as mental health services. Additional services are particularly needed in the rural areas of Oahu as well as the neighbor islands. Other needs include addressing the NIMBY (not in my back yard) syndrome[26], additional substance abuse programs as well as housing for dually diagnosed individuals, and greater utilization of existing services[7,22]. The latter could be facilitated by training clients, family members, and police to recognize early signs of psychological deterioration and an emerging crisis so that mental health services could be sought as early as possible.

The Needs of Children and Adolescents

A significant gap exists between the number of children needing services and the number receiving them, with estimates of 70-80% of children and adolescents in need of services not receiving them[27-29]. Not surprisingly, the demand for services is increasing, as evidenced by frequently inappropriate psychiatric hospitalization as well as rising youth suicide, crime, and substance abuse rates (e.g., in the late 1990s, Hawaii's youth had a 26% increase in violent crime, while national rates dropped 9%)[29,30]. As untreated behavioral disorders are an etiological factor for the increased rates of crime and suicide amongst Hawaiian youth[29], adequate access to treatment is critical for youth with these disorders.

A range of services accessible in their communities are needed by children and adolescents. Needed non-residential services include more prevention (e.g., substance abuse, prenatal care, parenting skills training to prevent child abuse), early identification of and treatment for mental health problems (including assessment services), home-based services, day treatment services for individuals with SMI, and crisis services (e.g., suicide prevention clinics) [8,12]. There is also a need for more state funded residential services, including therapeutic foster homes, therapeutic group homes, independent living services for older adolescents, and crisis residential services.

Significant improvements are, however, being made in service provision to children and adolescents. Better collaboration between the DOH and the Department of Education[31] (who makes many of the referrals to CAMHD) is responsible for some of these improvements. Further, the CAMHD has been undergoing a large-scale reorganization[32], which has led to a recent termination of the failure to meet the mandates of the Felix consent decree[33].

Domestic violence victims

One way unresolved mental health problems express themselves is through domestic violence, the latter of which is a major and growing problem in Hawaii. Between 1998 and 2002, there was an increase of 65% in reported child abuse and a 60% increase in confirmed cases[34]. Spousal/partner abuse and homicide rates are also on the rise with 25% of women in the state experiencing spousal/partner abuse[41]. However, these figures may underestimate the extent of the problem, as large metaanalytic studies on domestic

violence reveal that as many as 70% of women never report the abuse[36, 37].

A variety of resources are needed for this population with fiscal and personnel deficiencies again being greater on the outer islands than Oahu. There is a serious deficit in the number of needed shelters for battered women and their children (which battered women typically rate as their most important need[38]), and they are usually filled to capacity[39]. There is also a lack of needed resources for advocacy, outreach, as well as case management and other treatment services for victims (with services for adolescent victims of partner abuse being especially sparce)[14,40]. Lenient sentencing of perpetrators, which results in high rates of repeat offenses, is another problem[14]. Another need is better coordination between mental health and other service providers, such as Child Protective Services, Adult Probation Services, schools, and police[14]. Further, there are insufficient domestic violence intervention services for offenders (with no services provided to short-term (up to one year) incarcerated offenders)[40]. As native Hawaiians are overrepresented among the spousal and child abuse perpetrator population[34,41], access to culturally sensitive mental health services is critical for optimal outcomes for this population.

Ethnically Diverse Clientele

The population of Hawaii is one of the most ethnically diverse in the United States, consisting of an exceptional array of some 20 different ethnic groups, with no ethnic majority[32]. Hence, the provision of culturally sensitive therapy, is of paramount importance in Hawaii given research indicating that the single most important reason for both the underutilization of mental health services by ethic minority clients and their high premature dropout rates is the failure of therapists to provide culturally sensitive therapy[42]. There is a need for more therapists with adequate training in this area as 70% of the current generation of clinical supervisors had no formal training in dealing with multicultual issues[43]. In addition, there is a need for more bilingual therapists in Hawaii as well as more therapists of ethnically diverse backgrounds, given that for some clients, ethnic matching of client and therapist is related to lower premature termination rates[43]. Willingness to modify conventional forms of treatment is also beneficial for many clients in Hawaii (e.g., incorporation of traditional healing practices). Although the incorporation of indigenous healing practices has not been shown to improve outcome for clients who complete therapy, the research does show that ethnically diverse clients are more likely to seek services from therapists and agencies that utilize such practices and are again less likely to drop out of counseling prematurely[44].

Conclusion

Although service provision has increased in recent years, the population in need of mental health services in Hawaii is still seriously underserved. Reforms need to occur in a variety of areas such as budget and fiscal polices, management and hiring of staff, coordination between various types of service providers, and cost-efficiency. Greater resources are needed at the community level and the results of needs assessments for a variety of groups were explicated. Ensuring that mental health professionals employed by the state are trained in the provision of culturally sensitive services will enhance the efficacy of services offered by the various agencies. Despite past problems and likely ongoing difficulties, the public mental health system of Hawaii is continuing to make improvements in policies and services that positively impact the lives of their clients.

References

1. Gochros, SL. "Reinventing" governance of Hawaii's public mental heath delivery system - problems, options, and possibilities. Honolulu (HI): Legislative Reference Bureau; 1994.
2. Torrey, EF, Wolfe, SM. Care of the seriously mentally ill: A rating of state programs. Washington (DC): Public Citizen Health Research Group; 1986.

*See "**References**" p. 81*

"References" from p.67

3. Torrey, EF, Erdman, K, Wolfe, SM, Flynn, LM. Care of the seriously mentally ill: A rating of state programs. Washington (DC): Public Citizen Health Research Group & the National Alliance for the Mentally Ill; 1990
4. Honolulu Advertiser. (1992, November 27)
5. Felix v. Waihee. Civil No. 93-00367. First Amended Complaint for Declaratory and Injuctive Relief. United District Court (Class Action). (1993).
6. Auditor. Study of privatizing adult mental health program services. Report No. 01-13. Honolulu: State of Hawaii: 1999a.
7. Rees, RM. Hawaii and the mentally ill. Videorecording; 2001.
8. Auditor. Study in the privatization of the child and adolescent mental health program. Report No. 99-12. Honolulu: State of Hawaii; 1999b.
9. Auditor. Audit of the adult mental health program. Report No. 01-13. Honolulu: State of Hawaii; 2001.
10. Auditor. Adit of the adult mental health division's management of contracted community services. Report No. 02-06. Honolulu: State of Hawaii; 2002.
11. Osborne, D, Gaebler, T. Reinventing government: How the entrepreneurial spirit is transforming the public sector. New York (NY): Penguin; 1992.
12. Department of Health. Child and Adolescent Mental Health Division: Performance report. Honolulu: Author; 2003.
13. Center for Alternative Dispute Resolution. Unserved mental health needs and prescriptive privileges for psychologists in Hawaii: A report on the psychotropic medications roundtable. Honolulu (HI): Author, Dispute Resolution; 1990.
14. Department of the Attorney General. A review of domestic violence and sexual assult issues in Hawaii. Honolulu: Author; 1999.
15. Cohen, S, Syme SL. Social support and health. San Francisco (CA): Academic Press; 1985.
16. Ornish, D. Love and survival: The scientific basis for the healing power of intimacy. New York (NY): Harper-Collins; 1998.
17. Sarason, BR, Sarason, IG, Pierce, GR, editors. Social support: An interactional view. New York (NY): John Wiley & Sons; 1990.
18. VanderVoort, DJ. Quality of social support in mental and physical health. Current Psy 1999; 33: 331-336.
19. Wills. TA, Filer, M. Social networks and Social support. In: A, Baum, TA, Revenson, JE. Singer, Editors. Handbook of Health Psychology. Mahwah(NJ): Lawrence Erlbaum; 2001. p. 209-234.
20. Department of Business, Economic Development, and Tourism. The State of Hawaii Data Book 2002: A statistical abstract. Honolulu: Author; 2002.
21. Lanzilotti, SS. Developing, coordinating, and implementing an integrated plan to meet the needs of our elderly population. Honolulu: City and County of Honolulu; 2003.
22. Wylie, AM, Crockett, JC. Hawaii's community mental health centers: 1994 needs assessment. Technical Report #940601. Kaneohi (HI): Adult Mental Health Division, State of Hawaii; 1994.
23. Drake, RE, Wallach, MA. Substance abuse among the chronically mentally ill. Hospital and Community Psychiatry. 1989; 40:1041-1046.
24. Marticle, RA, Hoffman, WF, Bloom, JD, Faulkner, LR, Keepers, GA. The prevalence and significance of medical illness among chronically mentally ill outpatients. Community Ment Health J 1987; 23: 81-90.
26. Segal, SP, VanderVoort, DJ, Liese, LH. Residential status and the physical health of a mentally ill population. Health Soc Work 1993; 18: 208-214.
26. KFVE. Care fo the mentally ill in Hawaii. Videorecording; 1991.
27. Maser, N, O'Donnell, MJ. The future of the child and adolescent mental health system in Hawaii. Honolulu (HI): Bank of Hawaii; 1992.
28. Burns, BJ, Costello, EJ, Angold, A, et al. Children's mental health services use across service sectors. Health Affairs 1995; 14: 147-159.
29. Hogan, MF. A partly built bridge between science and services: Commentary on the Hawaii Empirical Basis to services Task Force. Clin Psy: Sci Pract 2002; 9: 200-203.
30. Simmons, C. Who will speak for the youth? Videorecording. Honolulu(HI): KHET; 1997.
31. Higa, MM. Follow-up report on a study of the memorandum of agreement for coordinating mental health services to children: A report to the governor and the legislature of the state of Hawaii. Honolulu(HI): Office of the Auditor; 1995.
32. Chorpita, BF, Letitia, MY, Donkervoet, JC, et al. Toward large-scale implementation of empirically supported treatments of children: A review and observations by the Hawaii Empirical Basis to Services Task Force. Clin Psy: Sci Pract 2002; 9: 165-190.
33. Kim, S.P. (2005). Personal communication.
34. Department of Human Services. A statistical report on child abuse and neglect in Hawaii. Honolulu(HI): Author; 2002.
35. Department of Health. Violent and abusive behavior. Honolulu (HI): Author; 2000.
36. Henderson, H. Domestic violence and child abuse sourcebook. Detroit(MI): Omnigraphics; 2000.
37. Lanzilotti, SS. Pre-hospital emergency medical care domestic violence program. Honolulu(HI): City and County of Honolulu; 2003.
38. Pacific Behavioral Health Services. Domestic violence in Hawaii: Impact on mothers and their children. Honolulu (HI): Hawaii Correctional Industries; 2000.
39. Bintliff, S. Domestic Violence: Myths and barriers. HI Med J 1996; 55: 159-161.
40. Department of the Attorney General. Domestic violence and the criminal justice system. Honolulu (HI): Author; 1999.
41. Furuto, SM. Family violence among Pacific Islanders. In: N. Mokuau, editor. Handbook of social services for Asian and Pacific Islanders. New York(NY): Greenwood Press; 1991.
42. Essandoh, PK. Multicultural counseling as the "Fourth Force": A call to Arms. Couns Psy 24; 24: 126-137.
43. Atkinson, DR. Lowe, SM. The role of ethnicity, cultural knowledge, and conventional techniques in counseling and psychotherapy. In: JG Ponterotto, JM Casas, LA Suzuki, CM Alexander, editors. Handbook of multicultural counseling. Thousand Oaks (CA): Sage Publications; 1995. p 387-414.
44. Sue, S. In search of cultural competence in psychotherapy and counseling. Am Psy 1998; 53: 440-448.

Classified Notices

To place a classified notice:

HMA members.–As a benefit of membership, HMA members may place a complimentary one-time classified ad in HMJ as space is available.

Nonmembers.–Rates are $1.50 a word with a minimum of 20 words or $30. Not commissionable.

For more information call (808) 536-7702.

Office Space

FULLY FURNISHED OFFICE IN MOILIILI—AVAILABLE IN OCTOBER 2005. 1000 sq. ft. includes three examination rooms, spacious work area for personnel and multiple shelving for charts. Large doctor's office. Interior decorated-designed waiting room. For further information call (808) 949-6665.

For Sale

BUSY PRACTICE; INTERNAL MEDICINE / FAMILY MEDICINE — AT ST. FRANCIS WEST MOB. Options available. Inq: 488-7770. Jeanette.

Office Space & Support Services

ALA MOANA BLDG.— PHYSICIAN WANTED to share space and support services. Interest in physical rehab. preferred. We have unique time-share arrangements starting at one half-day per week. Run your practice with no fixed overhead. Contact Dr. Speers, REHABILITATION ASSOCIATES, 955-7244.